SKINTASTIC

Medical & Surgical Skin Rejuvenation Centers
skintastic.com

JEFFREY ADELGLASS, M.D., F.A.C.S.

COSMETIC PATIENT HEALTH HISTORY

Date ____________________ Referred By ____________________

First Name ____________________ Last Name ____________________

Address ____________________

City ____________________ State ____________________ Zip ____________________

Phone (home) ____________________ Phone (work) ____________________ Phone (cell) ____________________

Date of Birth ____________ Age ________ SSN ____________ Driver's License # ____________

E-mail ____________________ Occupation ____________________

Marital Status (circle one)Single / Married / Separated / Divorced / Widow ____________________

Emergency Contact ____________________ Phone ____________________ Relationship ____________________

Family Physician ____________________ Phone ____________________ City / State ____________________

What is the best way to contact you? ❒ home ❒ work ❒ cell ❒ email ❒ mail

How did you hear about us? Friend (name):____________________ ❒ Internet ❒ Radio ❒ Mailer
❒ Magazine ❒ Yellow Pages ❒ TV Guide ❒ Other Newspaper ❒ Other

Do we have permission to obtain additional health information from your family physician? ❒ Yes ❒ No

*Do you have any allergies or sensitivities? ❒ Yes ❒ No If yes, please list ____________________

*Are you currently taking any medications? ❒ Yes ❒ No If yes, please list ____________________

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Are you currently taking aspirin, ibuprofen, minerals, herbs, nutritional supplements, birth control pills or sexual performance drugs? ❒ Yes ❒ No

If yes, please list. ____________________

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Please check the procedure(s) in which you might be interested.

❒ Botox	❒ Full Face Lift	❒ Restylane	❒ Sculptra	❒ Radiesse
❒ Artefill	❒ Fat Transfer	❒ QuickLift™	❒ Gentlelift	❒ Refirm
❒ Fotofacial	❒ Cellulite Reduction	❒ Filler	❒ Juvederm	❒ Cheek Implant
❒ Microdermabrasion	❒ Brow Lift	❒ Eyelid Surgery	❒ Rhinoplasty	❒ Otoplasty
❒ Fraxel	❒ Spider Veins	❒ LED	❒ BlueLight	❒ Hair Removal
❒ Thermage	❒ Chemical Peel	❒ Laser Peel	❒ Lipo Smart	❒ Other

When did you first consider cosmetic surgery? ______________________________

Have you consulted with another doctor? ❒ Yes ❒ No

Have you pursued other alternatives? ❒ Yes ❒ No

*If yes, please specify*______________________________

Have you had previous cosmetic, plastic or reconstructive surgery? ❒ Yes ❒ No

What type of surgery? ______________________ Date ______________________

By whom? ______________________________

Where there aspects of your surgery that did not meet your expectations? ❒ Yes ❒ No

If yes, please specify______________________________

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Have you ever had any other type of surgery? ❒ Yes ❒ No

Type of surgery ______________________ Date ______________________

Type of surgery ______________________ Date ______________________

Type of surgery ______________________ Date ______________________

Did you experience any complications? ❒ Yes ❒ No

If yes, please specify______________________________

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Have you ever had local anesthesia (Novocain, Xylocaine, etc) by a dentist or doctor? ❒ Yes ❒ No

Have you ever experienced an adverse reaction to anesthesia? ❒ Yes ❒ No

If yes, please describe the type of reaction______________________________

When was your last physical examination? ______________________________

Do you have a history of bleeding? ❒ Yes ❒ No

If yes, please specify______________________________

Please explain and list any other bleeding problems. ______________________________

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PLEASE CHECK ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST (CONT. ON NEXT PAGE…)

Allergies	❒ Yes	❒ No	High / Low Blood Pressure	❒ Yes	❒ No
Hay Fever	❒ Yes	❒ No	Kidney Disease	❒ Yes	❒ No
Nasal Allergies	❒ Yes	❒ No	Bladder Disease	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	Arthritis	❒ Yes	❒ No
Vision / Eye Problems	❒ Yes	❒ No	Decreased circulation (fingers/toes)	❒ Yes	❒ No
Chest Pains	❒ Yes	❒ No	Skin Infections	❒ Yes	❒ No
Stomach Ulcers	❒ Yes	❒ No	Skin Irritations	❒ Yes	❒ No
Lung Disease	❒ Yes	❒ No	Skin Rashes	❒ Yes	❒ No

PLEASE CHECK ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST

Liver Disease	❐ Yes	❐ No	Herpes	❐ Yes	❐ No
Gall Bladder Disease	❐ Yes	❐ No	HIV/Aids	❐ Yes	❐ No
Yellow Jaundice	❐ Yes	❐ No	Sexually Transmitted Disease	❐ Yes	❐ No
Severe Headaches	❐ Yes	❐ No	Seizures	❐ Yes	❐ No
Dizzy Spells	❐ Yes	❐ No	Depression	❐ Yes	❐ No
Paralysis/Numbness	❐ Yes	❐ No	Mitral Valve Prolapse	❐ Yes	❐ No
Bruise Easily	❐ Yes	❐ No	Autoimmune Disease (Lupus, MS)	❐ Yes	❐ No
Hysterectomy	❐ Yes	❐ No	Menopause	❐ Yes	❐ No
Neuro Muscular Disease	❐ Yes	❐ No			

If you answered yes to any of the above, please explain and list medications that are being used to treat the condition

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Do you or any family members have the following (please indicate relationship)?

Heart trouble	❐ Yes	❐ No	Relationship ____________________
Excessive bleeding	❐ Yes	❐ No	Relationship ____________________
Diabetes	❐ Yes	❐ No	Relationship ____________________
Thyroid problems	❐ Yes	❐ No	Relationship ____________________
Excessive bruising	❐ Yes	❐ No	Relationship ____________________
Unfavorable/wide scarring	❐ Yes	❐ No	Relationship ____________________
Delayed or poor healing	❐ Yes	❐ No	Relationship ____________________
Psychiatric or nerve problems	❐ Yes	❐ No	Relationship ____________________
Arthritis	❐ Yes	❐ No	Relationship ____________________
High blood pressure	❐ Yes	❐ No	Relationship ____________________
Low blood pressure	❐ Yes	❐ No	Relationship ____________________
Depression	❐ Yes	❐ No	Relationship ____________________
Other _______________	❐ Yes	❐ No	Relationship ____________________

Are you frequently sick or ill?	❐ Yes	❐ No
Have you ever taken hormone or thyroid medications?	❐ Yes	❐ No
Do you smoke cigarettes?	❐ Yes	❐ No
How many per day?	_________ pks	
How many years?	_________ yrs	
Do you drink more than 6 cups of coffee per day?	❐ Yes	❐ No
Do you normally have more than 2 drinks of alcohol per day?	❐ Yes	❐ No
Are you currently on a weight loss plan or have been on one in the last year?	❐ Yes	❐ No
On the average, how many hours a night do you sleep?	_________ hrs	
On a scale of 1-10 what would you say your level of stress is? (10 being the most)	____________	

Have you ever been under the care of a psychologist or psychiatrist? ❒ Yes ❒ No

If yes, please explain. ____

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Ethnicity: This information is very important in order for your aesthetician to serve you correctly, and insure the best possible results for your skin treatment. (Please circle one)

Anglo-Saxon (Caucasian), Hispanic, Asian, African American, Indian, Middle Eastern, Other (please specify)________________

Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome? ❒ Yes ❒ No

Do you understand that all risks and complications cannot be prevented when a surgical procedure is performed? ❒ Yes ❒ No

Appointment: In an effort to stay on schedule, please arrive a few minutes prior to your appointment. Being on time for your appointment assures you will receive your full service and that our other clients are not inconvenienced. We reserve the right to reschedule your appointment if you are late. Please schedule your next appointment before you leave.

Cancellations: We respectfully request 24 hours notice for appointment rescheduling and cancellations. A minimum $50.00 fee will be charged for appointments not cancelled or rescheduled within 24 hours of your scheduled appointment time.

Policy: Products may not be returned for refunds or credit applied to services, we will not exchange products. Series must be paid for in full prior to service to obtain series pricing and are non-refundable under any circumstances.

Insurance: Our services are cosmetic and are NOT covered by insurance plans.

Patient's signature ________________________________ Date ________________

Physician's signature ________________________________ Date ________________

Reviewed by ________________________________ Date ________________